Coalition to Protect the Rights of New York's Dually Eligible

Testimony of the Coalition to Protect the Rights

of New York's Dually Eligible

On

The Joint Legislative Public Hearing on 2013-2014 Executive Budget Proposal: Topic Health/Medicaid

Submitted to:

The Assembly Committee on Health

And

The Senate Health Committee

Submitted by

Doug Goggin-Callahan, Esq., 212.204.6275, dgoggin-callahan@medicarerights.org, New York State Policy Director at the Medicare Rights Center

on behalf of the Coalition

January 30, 2013

The **Coalition to Protect the Rights of New York's Dually Eligible** is a coalition of disability rights and senior rights advocates, consumers, community-based organizations, and lawyers representing people with disabilities and older New Yorkers. Many of our organizations directly serve New Yorkers eligible for both Medicare and Medicaid, also known as dual-eligibles or duals. We know that these individuals are some of the most vulnerable people in our communities. They are at or below the federal poverty level and are more likely to be in ill health than beneficiaries enrolled in only Medicare or only Medicaid.[1] It is critical that any changes in health insurance and care delivery for these individuals prioritize better care management and address their numerous and complex health problems. We thank you Chairman DeFransisco, Chairman Farrell, Chairman Gottfried, and Chairman Hannon for holding this hearing and providing our Coalition with the opportunity to speak to some of the executive budget provisions affecting dual-eligibles.

The Governor's budget authorizes the creation of the fully integrated dual advantage (FIDA) demonstration program and makes provisions for moving the demonstration forward, particularly for those who receive services through the Office for People with Developmental Disabilities (OPWDD). The FIDA demonstration builds on the existing movement of beneficiaries who receive more than 120 days of community-based care from the fee-for-service Medicaid program into a private managed long-term care (MLTC) plan. The FIDA demonstration would create new private insurance plans that would be responsible for all Medicare, Medicaid, and prescription medication services—not just long-term care services—to nearly 130,000 dually eligible New Yorkers. The demonstration would also create a subset of FIDA plans for 10,000 New Yorkers receiving services through OPWDD.

These plans hold the promise of coordinating care for beneficiaries rather than expecting them to navigate multiple plans and health systems on their own. At the same time, consumer advocates have a number of concerns that must be addressed before beneficiaries are enrolled into FIDA plans. Some of these concerns apply to the legislative language in the executive budget and we ask the legislature to amend the budget to ensure that needed beneficiary protections are built into the FIDA demonstration.

Section (c) grants the Commissioner of Health and the Commissioner of Developmental Disabilities the right to waive any Department of Health or OPWDD regulations he/she deems necessary to allow OPWDD FIDA plans to provide or arrange health care services. Because these new plans will provide both Medicare and Medicaid services and may have different marketing, appeals, and enrollment rules, it is likely the Commissioners will need to waive a number of regulations and sub-regulations to allow the demonstration to move forward. The Department of Health has been very open to stakeholder input and we thank them. We want the demonstration project to be afforded the flexibility needed to innovate and improve existing managed care systems, but that flexibility cannot come at the expense of public engagement and stakeholder participation. ***Condition broad waiver authority on stakeholder engagement or a requirement that regulatory change move through the State Register with an adequate opportunity for public notice and comment.***

[1] *See: Medicare: Strong and Built to Last,* Medicare Rights Center, November 2012: http://www.medicarerights.org/pdf/Medicare-Strong-Built-to-Last-2012.pdf

The establishment language in (a) rightly identifies the FIDA initiative as a program jointly conceived and developed by the Department of Health and the Centers for Medicare & Medicaid Services (CMS), but it fails to note that FIDA is a demonstration, not a permanent health program. If New York's demonstration proposal is approved by CMS, there will be ongoing monitoring and oversight to ensure that beneficiaries are provided with coordinated care and that savings are achieved for both the Medicare and Medicaid programs. Simultaneously, New York will be monitoring other developing health coordination programs, such as Accountable Care Organizations (ACOs) and health homes, to determine which models best serve different Medicaid populations. Ultimately, FIDA plans may become a permanent health care program and may expand to other populations, but that is a decision that should be made during the demonstration program, in consultation with CMS, the legislature, beneficiaries, providers, and other stakeholders. **We ask the legislature to add language to the establishment subsection to indicate that the program, if approved, will act as a demonstration.**

We are also concerned that subsection (f) authorizes the Commissioner of Health to contract with managed long-term care plans to provide services to all FIDA enrollees without requiring a competitive bid or request for proposal (RFP) process. Given the proposal to begin FIDA plan enrollment in January 2014, we understand the need for expediency in selecting health care plans that will provide services to FIDA enrollees, and recognize that the RFP process slows down plan selection. However, given the newness of this program, the health care needs of the demonstration population, and the still developing rules and standards governing these plans, we believe a public and transparent plan selection process is needed. Therefore, we believe a competitive bid or RFP process is needed.

Alternatively, if an RFP or competitive bid process is not possible, the Department of Health and OPWDD, in collaboration with stakeholders, must establish clear and transparent guidelines for plan selection. The Department of Health has convened several stakeholder workgroups, some of which have begun to address plan selection criteria. Advocates on the plan quality workgroup have identified a number of metrics related to network adequacy and compliance with the Americans with Disabilities Act (ADA) that would bear on plan selection.[2] These metrics, along with others, could serve as the base for the plan selection guidelines.

We urge the legislature to mandate FIDA plan selection on the basis of an RFP, or alternatively a selection process with clear and transparent guidelines developed in conjunction with stakeholders.

The authority to contract with the managed care plans lies with the Commissioner of Health. Although the Commissioner is required to consult with the Commissioner of Developmental Disabilities, approval from the Commissioner of Developmental Disabilities is not needed. We believe this is inadequate, particularly for the plans which will serve the 10,000 OPWDD FIDA enrollees. Given the unique and often high health care needs of this population, plan approval should come from both Commissioners.

We are also concerned that subsection (c) grants the Commissioner of Health the authority to select "up to three managed long-term care plans" to provide FIDA plans for the 10,000 New Yorkers who receive services through OPWDD and are eligible for the demonstration. This language suggests that the

[2] The full list of suggestions is available for download here: http://www.wnylc.com/health/download/310/

Commissioner could select only one FIDA plan provider for OPWDD FIDA enrollees. We do not want to be prescriptive and suggest the "right" number of plans from which FIDA enrollees can choose. *Meaningful* choice is more important than the number of plans available, but we do not believe that one or two plan options could provide a beneficiary with a meaningful health care choice. As noted, **the legislature should require the Department of Health to develop clear and transparent criteria for plan selection.** This would help ensure that, regardless of the number of plans selected by the Commissioners of Health and Developmental Disabilities, the plans that are selected are well poised to meet the health care needs of this population—and the right number is selected for providing meaningful choice.

As noted, the FIDA program builds upon the existing move of beneficiaries from fee-for-service Medicaid into managed long-term care plans. Notably absent in the executive budget language are clear incentives within managed care to provide services for people with disabilities in the most integrated setting. We strongly urge the state to employ rate-setting methodologies that incentivize community-based services and assure compliance with *Olmstead*. The Coalition to Protect the Rights of New York's Dually Eligible in collaboration with other advocates have already provided specific recommendations to the State.[3] These mechanisms could include establishing an outlier rate cell for the small group of highest-need individuals or, at a minimum, establishing stop-loss payments for community-based care for high-need individuals, as opposed to stop-loss payments for nursing facility care. This stop-loss mechanism would only be available to members who remain in the community. In addition, the state should employ performance measures to provide incentives for community-based services (e.g., supporting nursing facility diversions and transitions; ensuring that the community is the first default; requiring that consumer-directed services be the first option for enrollees; supporting the use of assistive technologies that maintain independence in the community; and complying with quality of care and quality of life measures, both medical and social), and sanction health plans for failing to comply with certain benchmarks. Managed care is promoted as providing the right care in the right place at the right time, but the provision of long-term services and supports is more than a "health care" issue—it is also a civil rights issue. The state should not use managed care only to control costs, but must also use managed care as mechanism to move the state forward in its compliance with *Olmstead.* To do this, the state must build incentives for community-based services into the rate-setting methodology, as well as into contract language.

We once again thank the Chairmen for convening this hearing. As the FIDA demonstration moves forward, we look forward to continuing to work closely with the Department of Health and the legislature to ensure that needed protections are in place for dually eligible New Yorkers. If you have any questions, please do not hesitate to contact Doug Goggin-Callahan by e-mail at dgoggin-callahan@medicarerights.org or by phone at 212-204-6275

3 *See*: *Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: Consumer Advocate Recommendations for New York State*, March 23, 2012: http://wnylc.com/health/download/304/